

# **BYLAWS OF THE MEDICAL STAFF**

## **UNIVERSITY OF NORTH CAROLINA HOSPITALS**

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**BYLAWS OF THE MEDICAL STAFF  
THE UNIVERSITY OF NORTH CAROLINA HOSPITALS**

**Article I:  
Mission**

The mission of The University of North Carolina Hospitals is to provide high quality patient care, to educate health care professionals, to advance health research and to provide community service. Recognizing that the Medical Staff is responsible for the quality of medical and dental care in the Hospital, subject to the ultimate authority of the Board of Directors of The University of North Carolina Health Care System, and that the best interests of the patient are protected by a concerted effort, the physicians, dentists and other personnel in The University of North Carolina Hospitals hereby organize themselves in conformity with these *Bylaws*.

**Article II:  
Definitions**

The following definitions apply to terms used in these *Bylaws*:

**“Board of Directors”** means the Board of Directors of the University of North Carolina Health Care System.

**“Hospital”** means The University of North Carolina Hospitals and all the activities, services and programs thereof, including, as appropriate to the context, the outpatient clinics, services, and programs of the University of North Carolina School of Medicine and the University of North Carolina Health Care System.

**“Housestaff”** means all physicians and dentists who are in recognized residency training programs sponsored by The University of North Carolina Hospitals. Housestaff are eligible for Medical Staff committee membership and for participation in Medical Staff conferences, seminars, and teaching programs.

**“Medical Review Committee”** means the Board of Directors and its committees, all Medical Staff committees, all Ad Hoc committees, and all Departments and Divisions when involved in evaluating the quality, cost of, or necessity for hospitalization or health care, including credentialing of Practitioners.

**“Medical Staff”** means all physicians and dentists with clinical privileges to treat patients at the Hospital.

**“Practitioner”** means a member of the Medical Staff, an Independent Allied Health Professional, or a Dependent Allied Health Professional with clinical or practice privileges at the Hospital.

**“President”** means the executive and administrative head of UNC Hospitals.

**“Physician”** includes both physicians and dentists, unless the context indicates otherwise.

**"Professional Review Activity"** means any activity of the Hospital with respect to an individual Practitioner (1) to determine whether an applicant or practitioner may have clinical or practice privileges at the Hospital or membership on the Medical Staff; (2) to determine the scope or conditions of such privileges or membership; or (3) to change or modify such privileges or membership.

**"Professional Review Body"** means, as appropriate to the circumstances, the Board of Directors, the Medical Staff Executive Committee, the Credentials Committee, any Ad Hoc Investigation Committee, any Hearing Committee, any Appellate Review Committee, the President of the Hospital, the Chief of Staff, any department, division, or service Chair, and any other person, committee, or entity having authority to make an adverse recommendation with respect to, or to take or propose an action against, any applicant or practitioner when assisting the Board of Directors in a Professional Review Activity.

Words used in these *Bylaws* are to be read as masculine or feminine gender, and as singular or plural, as the content requires. The captions and headings are for convenience only and are not intended to limit or define the scope or effect of any provision of the *Bylaws*.

### **Article III: Overview, Name and Purposes**

#### **Section 1. Overview**

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions, including, but not limited to, procedures for implementing the Medical Staff standards may be set out in Medical Staff Rules, Policies or Manuals adopted or approved as described below. Upon proper adoption, as described below, all such Rules, Policies or Manuals shall be deemed an integral part of the Medical Staff Bylaws.

#### **Section 2. Name and Purposes**

The physicians and dentists with clinical privileges are hereby organized as the "Medical Staff of The University of North Carolina Hospitals."

At the direction of and as delegated by the Board of Directors, the Medical Staff has the following responsibilities:

1. To undertake that all patients admitted to or treated in any of the facilities, departments or services of the Hospital receive the best possible care;
2. To develop a high level of professional performance by all members of the Medical Staff through the appropriate delineation of clinical privileges and the continuous review and evaluation of the clinical activities of each member of the Medical Staff;
3. To provide the highest scientific and educational standards and to further the progress of all members of the Medical Staff in professional knowledge and skill;
4. To provide the highest scientific and educational standards for postgraduate, graduate, and undergraduate students in medicine;

5. To afford outstanding health care to the community;
6. To promulgate *Bylaws, Rules and Regulations* for the self-governance of the Medical Staff;
7. To provide an organized means whereby issues concerning the Hospital may be discussed by the Medical Staff with the Board of Directors and the President of the Hospital. Individual members of the Medical Staff have the right of attendance and voice at all meetings of the Board of Directors and its committees; and
8. To stimulate and carry out research.

**Article IV:  
Categories of the Medical Staff**

**Section 1. The Medical Staff**

All appointments to the Medical Staff are made by the Board of Directors and are to one of the following categories of the staff. All appointees are assigned to a specific clinical department. .

**Section 2. The Active Staff**

All members of the Active Staff must hold a faculty appointment in the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill. The Active Staff consists of physicians and dentists who have successfully completed an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or Commission on Dental Accreditation (CODA) residency training program in the specialty in which the applicant seeks clinical privileges. Each Department Chair must be certified in his/her specialty by a member board of the American Board of Medical Specialties (ABMS) or the American Dental Association (ADA) or possess comparable competence. In addition, after January 1, 2002, each new applicant to the Active Staff must be either certified, or in preparation for certification, by a member board of the ABMS or an ADA recognized specialty or subspecialty in which the applicant seeks clinical privileges. Physicians and dentists who apply for Active Staff membership prior to obtaining board certification may be accorded provisional Active Staff status not to exceed a period of two (2) years during which time the physician or dentist must successfully obtain board certification. If a specialty board requirement would preclude board certification within the two (2) year provisional period, the physician or dentist must successfully obtain board certification within six (6) years of initial appointment, unless an earlier time period is identified by his board. Provisional status pending successful board certification may be extended for an additional period of one (1) year upon determination of good cause. If a provisional member of the Active Staff fails to obtain board certification within these time limits, or is found to be ineligible for further preparation for board certification, the provisional Active Staff appointment will terminate automatically and such physician or dentist will not be entitled to the Hearing and Appellate Review procedures of Article X..

Following board certification, failure of a subsequent required or optional board certification examination by a member of the Active Staff will not automatically result in termination of Medical Staff membership. Physicians or dentists who are certified by boards other than a member board of the ABMS or ADA recognized specialty, and/or who receive their specialty training in countries other than the United States or Canada, must receive the specific

recommendation of the Department Chair prior to consideration by the Credentials Committee, and will be evaluated for Active Staff membership according to criteria relative to education, current licensure, training, experience, and current competence.

Members of the Active Staff are appointed to a specific department. They have primary responsibility for patient care and clinical education, and are entitled to exercise those clinical privileges granted to them by the terms of their appointment or reappointment. Within the scope of their clinical privileges, the Department Chair may administratively assign clinical responsibilities to Active Staff to best meet patient care and/or departmental needs at UNC Hospitals and the outpatient clinics, services and programs of the School of Medicine of the University of North Carolina at Chapel Hill and the University of North Carolina Health Care System.

All members of the Active Staff, except those who hold an appointment of Fellow or Clinical Instructor on the faculty of the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill, are entitled to vote, hold office and serve on Medical Staff committees. Those members of the Active Staff who hold such Fellow or Clinical Instructor faculty appointments are entitled to serve on Medical Staff committees, but may not vote or hold office.

### **Section 3. The Courtesy Staff**

A member of the Courtesy Staff must be a member of the Active Medical Staff of another hospital where s/he actively participates in quality improvement activities similar to those required of the Active Staff at UNC Hospitals. Appointment to the Courtesy Staff is intended to be a limited appointment for purposes of occasional inpatient admissions or outpatient care in accord with those clinical privileges as granted by the terms of the appointment, the goals of the Hospital, bed availability, and the needs of the Active Staff and their patients. The Courtesy Staff consists of physicians and dentists who are board certified or who possess all of the qualifications for board certification and are otherwise professionally qualified to attend patients in the Hospital. They are not required to hold a faculty appointment in the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill. (For purposes of these Bylaws, physicians and dentists who are certified or qualified for certification by a member board of the American Board of Medical Specialists (ABMS) or by the American Dental Association (ADA) satisfy the requirement for board certification. Physicians and dentists who are certified or qualified for certification by boards other than a member board of the ABMS or the ADA are evaluated as to eligibility for Courtesy Staff based upon criteria relative to education, current licensure, training, experience, and current competence. Practitioners who diagnose or treat UNC Hospitals patients via telemedicine link are subject to the credentialing and privileging processes of UNC Hospitals for Courtesy Staff. Courtesy Staff are appointed to a specific department and may attend meetings of the Medical Staff and Department to which they are appointed, but are not eligible to vote, hold office, or serve on Medical Staff Committees.

### **Section 4. The Affiliate Staff**

The Affiliate Staff consists of physicians and dentists who have an office-based practice and refer patients to the inpatient services or procedural areas of UNC Hospitals. Appointment to the Affiliate Staff is intended for the purpose of coordination of care and appropriate follow-up of the Affiliate Staff's patients after treatment at UNC Hospitals. Members of the Affiliate Staff are not eligible for clinical privileges or admitting privileges, and are not entitled to vote on Medical Staff

matters. Members of the Affiliate Staff may visit patients they have referred to UNC Hospitals and may have “read only” access to the patients’ paper and electronic medical record but may not write orders or entries of any kind in the medical record. Affiliate Staff may attend clinical conferences, seminars, educational programs, Medical Staff and Department meetings and use the Health Sciences Library.

#### **Section 5. The Emeritus Staff**

The Emeritus Staff consists of physicians and dentists who were members of the Active Staff of this Hospital and who have since been appointed to the Emeritus faculty rank in the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill. Admitting and clinical privileges are redefined at the time of appointment to the Emeritus Staff. Emeritus Staff members are appointed to a specific department and may serve on Medical Staff Committees, but are not eligible to vote or hold office.

#### **Section 6. The Honorary Staff**

The Honorary Staff consists of physicians and dentists who are recognized by the Hospital for their professional eminence or their noteworthy contributions to the health and medical sciences. They are not eligible to admit patients, vote, hold office, or serve on Medical Staff Committees.

#### **Section 7. Basic Responsibilities**

Each member of the Medical Staff will:

- a. Provide his/her patients with professional care that meets generally accepted standards of quality, provide for continuous care for his patients, and participate in all quality improvement activities of the Hospital and Medical Staff;
- b. Abide by the Medical Staff *Bylaws, Rules and Regulations*, and by all other Hospital and Departmental standards, policies, rules and regulations;
- c. Discharge such staff, department, service, committee and Hospital functions for which s/he is responsible by appointment, election or otherwise;
- d. Prepare and complete in a timely manner the medical records and all other required records of all patients s/he admits or in any way provides patient care services to in the Hospital;
- e. Participate in the teaching of fellows, housestaff, medical or dental students, nurses, student nurses and allied health personnel as required by his/her appointment;
- f. Encourage, promote, and when appropriate, participate in scientific investigation, as required by his/her appointment;
- g. Abide by the ethical principles of his/her profession; and
- h. Participate in continuing medical education.

**Article V:  
Allied Health Professionals**

**Section 1. Qualifications**

An Independent or Dependent Allied Health Professional who applies for practice privileges must be a member of the faculty or an employee of the School of Medicine, an employee of the Hospital, or a party to a contract with the Hospital. An Allied Health Professional is not a member of the Medical Staff but must fulfill all other applicable requirements specified in these *Bylaws* and all Medical Staff and Hospital rules, regulations, policies, and procedures.

**Section 2. Independent Allied Health Professionals**

- a. The term "Independent Allied Health Professional" includes: licensed acupuncturists; certified clinical geneticists; clinical pharmacists; optometrists; podiatrists; psychologists; holders of doctoral degrees affiliated with the Department of Pathology and Laboratory Medicine, or other departments; and others as designated by the Board.
- b. An Independent Allied Health Professional must meet those specific qualifications and may request only those specific practice privileges appropriate to his/her category, as specified by the applicable policies and procedures of the Credentials Committee and these *Bylaws*.
- c. An application for practice privileges will be processed in accordance with the procedures specified in Article VII for initial application to the Medical Staff. After an initial appointment of one year, an Independent Allied Health Professional must apply for renewal of practice privileges every two years.
- d. An Independent Allied Health Professional may not admit patients to or discharge patients from the Hospital. An Independent Allied Health Professional may, within the scope of his/her professional licensure or certification, his/her practice privileges, and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:
  - (1) provide specified patient care services;
  - (2) exercise independent judgment in his/her areas of competence and participate directly in the management of patients, provided that a member of the Active Staff within the appropriate department or specialty has overall responsibility for the care provided to each patient;
  - (3) enter reports and progress notes into the medical record and write certain treatment orders for specific patients;
  - (4) serve with voting rights on committees of the Medical Staff and attend Medical Staff or department meetings, if invited; and
  - (5) exercise other prerogatives, as specified by the Board.

### **Section 3. Dependent Allied Health Professionals**

- a. The term "Dependent Allied Health Professional" includes: certified registered nurse anesthetists; certified nurse midwives; clinical pharmacist practitioners; nurse practitioners; physician assistants; and others as designated by the Board.
- b. A Dependent Allied Health Professional must meet those specific qualifications and may request only those specific practice privileges within the scope of the licensing or certification requirements applicable to his/her profession, and as further specified by the policies and procedures of the Credentials Committee and these *Bylaws*. A Dependent Allied Health Professional must have a collaborative practice agreement or supervising physician agreement with one or more of the Active Staff who will supervise and assume responsibility for his/her patient care activities.
- c. An application for practice privileges will be processed in accordance with the procedures specified in the Article VII for initial application to the Medical Staff. After an initial appointment for one year, a Dependent Allied Health Professional must apply for renewal of practice privileges every two years.
- d. A Dependent Allied Health Professional may not independently admit patients to or discharge patients from the Hospital. A Dependent Allied Health Professional may, within the scope of his/her professional licensure or certification, his/her practice privileges, and the rules, regulations, policies and procedures of the Medical Staff and the Hospital:
  - (1) provide specified patient care services in collaboration with or under the supervision of his/her sponsoring Active Staff member or members;
  - (2) enter reports and progress notes into the medical record and write certain treatment orders for specific patients;
  - (3) serve with voting rights on committees of the Medical Staff and attend Medical Staff or department meetings, if invited; and
  - (4) exercise other prerogatives, as specified by the Board.

### **Section 4. Restriction, Suspension, or Termination of Practice Privileges**

- a. Allied Health Professionals are not members of the Medical Staff and accordingly shall have no recourse to the procedural rights specified in Articles IX and X .
- b. An Allied Health Professional shall promptly report to the Office of Medical Staff Services any significant change in information previously provided as part of prior applications for appointment or reappointment. This includes, but is not limited to: changes in professional licensure/certification, DEA, malpractice coverage, as well as involvement in any malpractice activity or disciplinary action by any licensing or certification board or healthcare facility.
- c. In the event that an Allied Health Professional's certification or licensure is adversely affected in any manner, his/her practice privileges shall be immediately and automatically restricted, suspended, or terminated accordingly.

- d. In the event that an Allied Health Professional's professional liability insurance is terminated for any reason, his/her practice privileges shall be immediately and automatically terminated.
- e. The practice privileges of a Dependent Allied Health Professional shall be automatically suspended or terminated if the clinical privileges of all his/her sponsoring or collaborative Active Medical Staff members are suspended or terminated for any reason.
- f. The President or Chief of Staff may restrict, suspend, or terminate any or all of the practice privileges of an Allied Health Professional without recourse to the procedural rights specified in Articles IX and X:
  - (1) An Independent Allied Health Professional whose practice privileges are restricted, suspended, or terminated will be notified of the action and the reasons for such action, and may request that such action be reviewed by the Medical Staff Executive Committee. At any such review meeting, the individual may be present and may participate in the review. The individual will be entitled to a written report at the conclusion of the review, but will not be entitled to any further internal review or appeal.
  - (2) A Dependent Allied Health Professional whose practice privileges are restricted, suspended, or terminated will be notified of the action and the reasons for such action, and may request that such action be reviewed by the Medical Staff Executive Committee. At any such review meeting, the individual and his/her sponsoring or collaborative Active Staff member or members may be present and may participate in the review. The individual will be entitled to a written report at the conclusion of the review, but will not be entitled to any further internal review or appeal.

**Article VI:  
Medical Staff Membership**

**Section 1. Membership**

Membership on the Medical Staff of the University of North Carolina Hospitals is a privilege extended only to physicians and dentists who continuously meet the qualifications, standards and requirements set forth in the *Bylaws*. Membership on the Medical Staff confers only those clinical privileges and prerogatives granted to the member by the Board of Directors in accordance with these Bylaws. Appointments to the Medical Staff are made without regard to race, religion, color, age, sex, national origin, disability, or sexual orientation, provided the individual is competent to render care consistent with the professional level of quality and competence established by the Medical Executive Committee and the Board of Directors.

**Section 2. Term of Appointment**

All initial appointments to the Medical Staff are for a period of one year from the date of appointment. Thereafter, reappointments are for a period of two years from the date of reappointment, except Emeritus Staff with clinical privileges are considered every year.

### **Section 3. Termination of Appointment**

Appointments and reappointments to the Medical Staff may be terminated prior to the expiration of the period of appointment or reappointment only by one of the following means:

- a. Voluntary resignation by a member of the Medical Staff, submitted in writing to the Office of Medical Staff Services;
- b. Automatic administrative action evidenced by the failure of the member of the Medical Staff to continuously meet the qualifications, standards and requirements set forth in the *Bylaws*, including by way of example and not limitation: failure to maintain a faculty appointment required for Active Staff or Emeritus Staff appointment; failure to obtain or maintain licensure, board certification status, or medical malpractice insurance required for the staff category; involuntary exclusion from participation in Medicare, Medicaid, or other federally funded health care programs; Drug Enforcement Administration certificate revocation, suspension, stay, restriction, or probation; or conviction of a felony. Termination of appointment by automatic administrative action is final and the individual shall not be entitled to the Hearing & Appellate Review Procedures of Article X; and
- c. Corrective action in accordance with Article IX.

### **Article VII: Procedure for Appointment and Reappointment**

#### **Section 1. Application for Appointment**

- a. All applications for appointment to the Medical Staff are submitted to the Chair of each Department in which an applicant requests privileges on the prescribed form and signed by the applicant. A decision by the Credentials Committee, the Executive Committee of the Medical Staff and the Board of Directors is made within a time period not to exceed 180 days from the receipt by the Office of Medical Staff Services of a complete application.
- b. Applicants for appointment to the Medical Staff have the burden of providing the information required in the application form, and any additional information reasonably required by the Credentials Committee to document or verify the applicant's qualifications and suitability for appointment to the Medical Staff. The Office of Medical Staff Services will promptly notify the applicant if any information is incomplete or missing from his/her application, and the applicant will have the obligation of obtaining the requested information. The application is considered complete when (1) all blanks on the application form are filled in and necessary explanations provided; (2) verification of past malpractice insurance and claims history has been received; and (3) peer reference evaluations and information from past Hospitals, training programs, and other affiliations have been received.
- c. An application provides detailed information concerning the applicant's qualifications including, but not limited to:

1. relevant education, training and experience to demonstrate that any patient treated will receive professional care that meets generally accepted standards of quality;
2. current licensure;
3. current competence in the applicant's respective fields;
4. ability to meet standards established in areas of general competency, including but not limited to patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
5. specific clinical privileges requested;
6. ability to perform the privileges requested;
7. willingness and ability, based upon documented references, to adhere to the ethics of the applicant's profession, to work cooperatively with others, and to fulfill the responsibilities of Medical Staff membership;
8. physical and mental health status, including evidence of immunity to mumps, measles and rubella, varicella, and pertussis;
9. involvement in any professional liability action, claim or suit;
10. previously successful or currently pending challenges to any licensure or registration or the voluntary or involuntary relinquishment of any license or registration;
11. voluntary or involuntary relinquishment of membership in a professional society;
12. voluntary or involuntary termination of Medical Staff membership at another Hospital;
13. voluntary or involuntary limitation, reduction or loss of clinical privileges at another Hospital;
14. relevant Practitioner-specific data compared to aggregate data and performance measurement data, including morbidity and mortality data, when available; and
15. any other qualifications set forth in these Bylaws.

The applicant also provides proof of professional liability insurance coverage in an amount of at least \$1,000,000 per claim.

- d. As part of the application, the applicant signs a statement that s/he has received and read the current *Bylaws of the Medical Staff, Rules and Regulations of the Medical Staff*, and Organization Manual and agrees to be bound by the terms thereof in all matters relative to his/her activities as a Medical Staff member and relative to consideration of his/her application without regard to whether s/he is granted membership and/or clinical privileges. The applicant also signs a statement that s/he has read and agrees to be bound by the terms of the University of North Carolina Health Care System Code of Conduct and its Physician Addendum.

## **Section 2. Effect of Application**

By applying for appointment to the Medical Staff, the applicant thereby consents to the inspection by Hospital representatives of records and documents pertinent to his/her current licensure, specific training and experience, current competence, and ability to perform the privileges requested, and agrees to appear for interviews with regard to his/her application. The applicant further authorizes Hospital representatives to consult with others who may have information bearing on his/her application, and releases from liability the Hospital, its representatives, and all other individuals and organizations for disclosing otherwise privileged or

confidential information in good faith and without malice in connection with the evaluation of his/her application.

### **Section 3. Appointment Process**

- a. The applicant has the burden of producing information sufficient for the proper evaluation of his/her application.
- b. The application is submitted to the Chair of each department in which the applicant requests privileges. The Chair of each such department reviews the application and supporting documentation and transmits to the Office of Medical Staff Services a written report with a recommendation to the Credentials Committee to either appoint the applicant to the Medical Staff, reject the applicant for staff membership, or defer the application for further consideration. Where appointment is recommended, the Chair further recommends the clinical privileges to be granted and any special conditions to be attached to the appointment. The Office of Medical Staff Services verifies from primary sources, whenever feasible, the applicant's references, education and training, board certification, licensure, insurance information, health status, and any other relevant information, and promptly notifies the applicant of any problems relative to verification efforts. The Credentials Committee, through the Office of Medical Staff Services, will seek confirmation of the Chair's recommendation upon receipt during the verification process of new or additional information that was not available to the Chair when s/he first reviewed the application.
- c. When verification by the Office of Medical Staff Services is complete, the Credentials Committee reviews the application, the supporting documentation, the Department Chair's report and recommendations, and such other information relevant to the staff category, department and service affiliation, and clinical privileges requested by the applicant. The Credentials Committee then recommends that the Executive Committee either appoint the applicant to the Medical Staff, reject the applicant for staff membership, or the Credentials Committee defers the application for further consideration. Where appointment is recommended, the Credentials Committee further recommends the staff category, department, and service affiliations, the clinical privileges (core and/or special, or office practice only) to be granted, and any limitations to the privileges or conditions to be attached to the appointment. In addition, the Credentials Committee, in accordance with policies adopted by the Board of Directors, determines whether the application qualifies for expedited consideration by the Executive Committee or contains issues that require presentation at the Executive Committee. Applications that do not qualify for expedited consideration include those with concerning patterns of medical liability or professional performance at prior institutions or other matters revealed in the applicant's background and reference checks.
- d. The Executive Committee, acting upon the recommendation of the Credentials Committee, determines whether to recommend to the Board of Directors that the applicant be appointed to the staff, rejected for staff membership or that the application be deferred for further consideration. All recommendations for appointment further recommend the clinical privileges to be granted and any conditions to be attached to the appointment. In addition, the Executive Committee determines whether the application qualifies for expedited consideration by the Credentials Committee of the Board of

Directors, or whether the application contains issues that require presentation to the full Board at its next meeting.

- e. When the recommendation of the Executive Committee is to defer the applicant for further consideration, a recommendation for either appointment to the Medical Staff or rejection for staff membership is made by the Executive Committee to the Board of Directors within sixty (60) days.
- f. When the recommendation of the Executive Committee is, in all respects, favorable to the applicant, it is forwarded together with all supporting documentation to the Board of Directors.
- g. When the recommendation of the Executive Committee is adverse to the applicant and entitles the applicant to a Hearing as provided in this Article X, the President provides written notice to the applicant of such adverse recommendation and the right to a Hearing within five (5) days of the date thereof by certified mail, return receipt requested. An adverse recommendation by the Executive Committee is not forwarded by the President to the Board of Directors until after the applicant has exercised, or has been deemed to have waived, his/her rights to a Hearing as provided in Article X.

If, after a Hearing as provided in Article X, the recommendation of the Hearing Panel is favorable to the applicant, the application and supporting documentation is forwarded to the Board of Directors for final action in accordance with the Appellate Review provisions of Article X.

- h. At its next regular meeting following its receipt of the recommendation of the Executive Committee, the Board of Directors acts on the matter. If the Board's decision is adverse to the applicant, the Board of Directors will take no final action until the applicant has had an opportunity to exercise his/her right to a Hearing.
- i. The Board of Director's decision with regard to staff membership and/or clinical privileges is final, except that the Board may defer final action by referring the matter back to the Executive Committee for further reconsideration. Any such referral back states the reasons therefore and establishes a time period within which a subsequent recommendation to the Board of Directors shall be made. If it is deemed appropriate, the Board may direct that a further Hearing be conducted to consider matters still in question. At its next regular meeting following receipt of the record of the Hearing and the subsequent recommendation by the Executive Committee, the Board of Directors makes a decision either to appoint the applicant to the Medical Staff or reject him/her for staff membership. All decisions to appoint specify the nature and scope of the clinical privileges granted to the applicant, including any conditions to be attached to the appointment.
- j. Whenever the decision of the Board of Directors is contrary to the recommendation of the Executive Committee, the Board of Directors submits the matter to the Joint Conference Committee for review and recommendation and considers such recommendation before making its decision final.
- k. When the decision of the Board of Directors is final, the President sends written notice of the Board's decision to the applicant.

- I. The applicant may not provide any patient care at the Hospital until s/he has received written approval to do so from the President.

#### **Section 4. Application for Reappointment**

- a. Applications for reappointment to the Medical Staff are mailed to members of the Medical Staff at least ninety (90) days prior to the expiration of a member's term of appointment. All such applications are submitted to the Office of Medical Staff Services on the prescribed form and signed by the staff member. As part of the application, the applicant signs a statement that s/he has received and read the current *Bylaws of the Medical Staff*, and *Rules and Regulations of the Medical Staff*, and related Policies and Manuals, and agrees to be bound by the terms thereof in all matters relative to his/her activities as a Medical Staff member and relative to consideration of his/her application without regard to whether s/he is granted membership and/or clinical privileges. The applicant also signs a statement that s/he has received, read and agrees to be bound by the terms of the University of North Carolina Health Care System Code of Conduct and its Physician Addendum.
- b. A complete application provides detailed information concerning: the staff member's current staff status; specific clinical privileges requested; ability to perform the privileges requested; current faculty status; current licensure; physical and mental health status; involvement in any professional liability action, claim or suit; currently pending challenges to any licensure or registration or the voluntary relinquishment of any such licensure or registration; voluntary or involuntary relinquishment of membership in a professional society; voluntary or involuntary termination of Medical Staff membership at another Hospital; voluntary or involuntary limitation, reduction or loss of clinical privileges at another Hospital; and any other qualifications set forth in these *Bylaws*. Staff members also provide proof of professional liability insurance coverage in an amount of not less than \$1,000,000 per claim.
- c. If an application for reappointment is not received by the Office of Medical Staff Services at least sixty (60) days prior to the expiration of a member's term of appointment, the member and the member's clinical Department Chair are notified in writing by the President that the member's Medical Staff membership and clinical privileges will be terminated unless a completed application is received by the deadlines identified by the Office of Medical Staff Services.

#### **Section 5. Reappointment Process**

- a. At least ninety (90) days prior to the expiration of each staff member's appointment or reappointment, the Office of Medical Staff Services requests the Department Chair in which the member has clinical privileges to review all pertinent information relative to each staff member eligible for reappointment.
- b. Each Department Chair's recommendation concerning the reappointment of a Medical Staff member and the nature and scope of the clinical privileges to be granted upon reappointment is based upon such member's professional performance, including relevant Practitioner-specific data compared to aggregate data, performance measurement data and morbidity and mortality data, when available; ethics and conduct; attendance and participation in staff affairs; relevant training and/or experience; compliance with the *Bylaws of the Medical Staff* and *Rules and Regulations of the*

*Medical Staff*; cooperation with Hospital personnel; use of the Hospital's facilities for patients; relations with other Practitioners and ability to work with others; satisfactory completion of such continuing education requirements as may be imposed by the North Carolina licensing boards, the Hospital, or applicable accreditation agencies; physical and mental capabilities; continuing status on the faculty of the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill, if applicable; contributions towards the Hospital's objectives of patient care, education and research if applicable; and general attitude towards patients, the Hospital and the public.

- c. The Department Chair (or the Chief of Staff when a Department Chair applies for reappointment) forwards his/her written recommendations regarding reappointment to the Credentials Committee via the Chair's Evaluation Form (a key part of the practitioner's ongoing professional practice evaluation), which references each of the above elements of performance to at least one of the six general competencies (Patient Care/Clinical Skills, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practice-Based Learning and Improvement, and Systems-Based Practice). Thereafter, the procedures set forth in Article VII, Section 3 are followed relative to applications for reappointment and/or renewal of, or changes in clinical privileges granted in connection therewith.

The Chair's Evaluation Form requires the Chair to evaluate each of multiple elements of the practitioner's performance as being satisfactory or unsatisfactory, provide an evaluation of overall performance as satisfactory or unsatisfactory, and then recommend in favor of or against reappointment and renewal of requested privileges. Any overall unsatisfactory evaluations and any recommendation for less than the full requested term of reappointment with all requested privileges disqualifies the applicant from expedited consideration and requires presentation of identified issues to the Executive Committee.

When the overall evaluation is satisfactory, individual unsatisfactory evaluations of specific elements do not necessarily require presentation to the Executive Committee. The Credentials Committee, working with the Office of the Chief of Staff and the applicant's Department Chair, may establish a plan for counseling of the individual and ongoing professional practice evaluation over the term of reappointment. When approved by the Board as conditions or terms for reappointment that do not limit the requested scope of clinical privileges or category of appointment, such counseling or practice evaluation or other requirements do not constitute corrective action as defined in Article IX.

- d. In their evaluation of applications for reappointment, members of the Credentials Committee, the Executive Committee, all appropriate departmental personnel, the Board of Directors, and the authorized representatives thereof are entitled to all of the rights, privileges, immunities and authority set forth in these *Bylaws*. If deemed appropriate, they investigate any of the matters that arise during the evaluation of the application.

All such investigations are coordinated through the appropriate Department Chair, or if the Department Chair is being investigated, through the Chief of Staff.

## **Section 6. Administrative Appointment**

- a. The President has the authority to grant an applicant an administrative appointment or reappointment to the Medical Staff with clinical privileges pending completion of the

credentials review process following the Credentials Committee's favorable review of an application for appointment or reappointment and recommendation to the President therefore.

- b. The President, in consultation with the Chief of Staff and/or Department Chair, may revoke an applicant's administrative appointment or reappointment and clinical privileges at any time before final action by the Board of Directors for good cause shown.
- c. An applicant is not entitled to the due process rights set forth in Article IX or X relative to any matter concerning an administrative appointment or clinical privileges sought or granted in connection therewith.

### **Section 7. Modification of Appointment**

A staff member may, at any time, request modification of his Medical Staff category or clinical privileges by submitting to the Department Chair a written application on the prescribed form. Such application is processed by the Office of Medical Staff Services pursuant to the procedures set forth in Section 5 of this Article.

## **Article VIII: Clinical Privileges**

### **Section 1. Delineation of Clinical Privileges**

- a. Medical Staff membership confers upon the appointee or reappointee only those clinical privileges delineated in the notice of appointment or reappointment. The exercise of such privileges within any Department is subject to the rules and regulations of that Department and to the authority of the Department Chair. All requests for clinical privileges are processed pursuant to the procedures for appointment and reappointment set forth in, respectively, Article VII, Sections 3 and 5.
- b. Every application for staff appointment contains a statement of the specific clinical privileges being requested by the applicant. A request for clinical privileges is evaluated based upon the criteria set forth in Article VII, Section 1, and other reasonable evidence of current ability to perform the privileges requested, including, but not limited to: peer recommendations; ethical character; and ability to work with others. It is also based upon an assessment, as appropriate, of an applicant's documented experience in categories of treatment areas or procedures, the results of treatment, and the conclusions drawn from relevant Practitioner-specific data compared to aggregate data, performance measurement data, and morbidity and mortality data, when available. The applicant has the burden of establishing his/her qualifications for the clinical privileges requested.
- c. An application by a staff member for a modification of clinical privileges pursuant to Article VII, Section 7 contains reasons for the request along with relevant information concerning training and experience.
- d. The renewal of clinical privileges is based upon the criteria set forth in Article VII, Sections 4 and 5, and other information deemed relevant thereto, including, but not limited to: peer recommendations; ethical character; participation in continuing medical education; and the ability to work with others. It is also based upon an assessment, as

appropriate, of an applicant's documented experience in categories of treatment areas or procedures, the results of treatment, and the conclusions drawn from quality improvement activities.

- e. The nature and scope of surgical procedures which a dentist may perform are specifically defined in the application for clinical privileges. The Credentials Committee obtains advice from the Dean of the School of Dentistry and the Chair of the Operating Room Committee relative to the nature and scope of dental surgical privileges requested by applicants. All dental surgical patients must undergo the same medical evaluation as patients admitted for other surgical services. A physician member of the Medical Staff is responsible for the care of any medical problem present at the time of admission or that may arise during Hospitalization.

## **Section 2. Temporary Privileges**

- a. When appropriate, the President, or his/her designee, may grant temporary clinical privileges for a limited period of time to qualified Practitioners who are not members of the Medical Staff on the recommendation of the Chair of the applicable Department or the Chief of Staff. Practitioners requesting temporary privileges submit a current curriculum vitae, proof of licensure, and evidence of current professional liability insurance coverage in an amount not less than \$1,000,000 per claim.
- b. Temporary privileges are granted to admit and treat patients only under irregular or emergency conditions, and only for the duration of the circumstances involved, not to exceed 120 days.
- c. In exercising temporary privileges, the Practitioner acts under the supervision of the Department Chair or the Chief of Staff, or his/her designee.
- d. For good cause shown, the President, after consultation with the Department Chair and/or the Chief of Staff, may terminate the temporary privileges, or any part thereof, of any Practitioner to whom they have been granted. If, at the time of such termination, there are patients of the Practitioner admitted to the Hospital, those patients are assigned to another staff member by the Department Chair or Chief of Staff.
- e. A Practitioner is not entitled to the due process rights set forth in Articles IX or X relative to any matter concerning temporary privileges.

## **Section 3. Emergency Privileges**

In the case of an emergency, any member of the Medical Staff to the degree permitted by his/her license may do everything possible to save the life of a patient. In such an emergency, a Medical Staff member may use all Hospital facilities, seek assistance from all Hospital personnel, and request any consultation. For purposes of this section, an "emergency" is defined as a condition that is likely to result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

#### **Section 4. Disaster Privileges**

- a. During disasters in which the emergency management plan has been activated, the President or Chief of Staff or his/her designee(s) has the option to grant disaster privileges. These individuals are not required to grant disaster privileges and can make such decisions on a case-by-case basis at their discretion.
- b. The President, Chief of Staff, or his/her designee(s) may grant disaster privileges upon completion of a brief information form and presentation of any of the following:
  - (1) A current picture Hospital ID card;
  - (2) A current license to practice and a valid picture ID issued by a state, federal or regulatory agency;
  - (3) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);
  - (4) Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances; and/or
  - (5) Presentation by current Hospital or Medical Staff member(s) with personal knowledge regarding the Practitioner's identity.
- c. The President, Chief of Staff, or his/her designee(s) will assign a member of the Medical Staff, in the Practitioner's specialty, if possible, to supervise the Practitioner who has been granted disaster privileges. The Practitioner who has been granted disaster privileges will display a Hospital photo ID badge at all times to allow staff to readily identify him or her. As soon as the immediate situation is under control, the Office of Medical Staff Services will verify the credentials via the same process as established under the *Bylaws of the Medical Staff* for granting temporary privileges to fulfill an important patient care need.
- d. Disaster privileges will immediately terminate once the emergency has ended, as notified by the Hospital. Disaster privileges may also be terminated on the discovery of any information or the occurrence of any event of a professionally questionable nature about the Practitioner's qualifications or ability to exercise any or all of the disaster privileges granted. The President or his/her designee may, after consultation with the Chief of Staff, or his/her designee, terminate any or all of the Practitioner's disaster privileges provided that, where the life or well-being of a patient is determined to be endangered by continued treatment by the Practitioner the President, Chief of Staff, or his/her designee(s) may terminate immediately a Practitioner's disaster privileges. In the event of any such termination, the Practitioner's patient(s) then in the Hospital will be assigned to another Practitioner by the President, the Chief of Staff, or his/her designee(s). The wishes of the patient(s) will be considered, where feasible, in choosing a substitute Practitioner.
- e. A Practitioner is not entitled to the procedural rights afforded by the Hearing and Appellate Review Procedure in Article X because of his or her inability to obtain disaster privileges or because of any termination or suspension of any disaster privileges.

**Article IX:  
Corrective Action**

**Section 1. Procedure**

- a. Whenever the activities or professional conduct of any Practitioner with delineated clinical privileges are considered to be detrimental to patient care, to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital, corrective action against such Practitioner may be requested by an Officer of the Medical Staff, the Chair of any clinical department, the Chair of any standing committee of the Medical Staff, the President, or the Board of Directors. All requests for corrective action are made in writing to the Executive Committee and set forth the specific activities or conduct which constitute the grounds for the request. A copy of such request is forwarded to the Practitioner by the Executive Committee within five (5) days of its receipt of the request, by certified mail, return receipt request. The Executive Committee forwards all requests for corrective action to the Chair of the department in which the Practitioner has privileges or to the Chief of Staff if the request involves a Department Chair.
- b. The Chair of the Executive Committee promptly notifies the President in writing of the receipt of all requests for corrective action and continues to keep the President fully informed of all action taken in connection therewith.
- c. The Chair of the applicable department or the Chief of Staff, as appropriate, convenes an Ad Hoc committee to investigate the charges and makes a report of the investigation to the Executive Committee within fourteen (14) days after the Ad Hoc committee has been convened to consider the request for corrective action. Pursuant to the investigation, the Practitioner against whom corrective action has been requested has an opportunity to meet with the committee to discuss, explain or refute the charges against him/her. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X apply thereto. An investigation by an Ad Hoc committee is an administrative matter and not an adversarial Hearing. A record of such proceeding is made and included with the committee's findings, conclusions and recommendations reported to the Executive Committee.
- d. Within fourteen (14) days after receipt of a report from an Ad Hoc investigating committee, the Executive Committee acts upon the request. If the corrective action being considered by the Executive Committee involves a reduction, suspension or revocation of clinical privileges, or a suspension or expulsion from the Medical Staff, the Practitioner is permitted to meet with the Executive Committee prior to acting on such request. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X apply thereto. A record of such proceeding is made by the Executive Committee.
- e. The Executive Committee may reject or modify the request for corrective action, issue a warning, a letter of admonition, or a letter of reprimand, impose terms of probation or a requirement for consultation, recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed suspension of clinical privileges be terminated, modified or sustained, or recommend that the Practitioner's staff membership be suspended or revoked.

- f. Any recommendation by the Executive Committee for the reduction, suspension or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X.

## **Section 2. Summary Suspension**

- a. The President, the Chief of Staff, the Chair of the department in which the Practitioner has clinical privileges, or their appointed designees, has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, all or any portion of the clinical privileges of a Practitioner with delineated clinical privileges. Such suspension shall become effective immediately upon imposition by individuals so empowered.
- b. Either the Chair of the department in which the Practitioner has privileges, or the Chief of Staff, convenes an Ad Hoc committee to investigate the matter and make a report thereof to the Executive Committee within fourteen (14) days after the effective date of the summary suspension. The procedural rights set forth in Article X apply to a Practitioner who is summarily suspended.
- c. Immediately upon the imposition of a summary suspension, the Department Chair or the Chief of Staff has authority to provide for alternate medical coverage for the patients of the suspended Practitioner admitted to the Hospital.

## **Section 3. Actions Not Constituting Corrective Action**

A Professional Review Body will not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a Hearing will not have arisen, in any of the following circumstances:

- a. The appointment of an ad hoc investigation committee;
- b. The conduct of an investigation into any matter;
- c. The restriction or suspension of a Practitioner's clinical privileges for a period of not longer than fourteen (14) days while an investigation is pending;
- d. The making of a request or issuance of a directive to an applicant or a Practitioner to appear at an interview or conference before the Credentials Committee, any ad hoc investigating committee, the President, or any other Professional Review Body in connection with any investigation prior to a proposed adverse recommendation or action;
- e. The denial or refusal to accept an application for initial appointment or reappointment to the Medical Staff, or for clinical privileges, (1) where the application is incomplete or (2) where the application reflects that the applicant does not meet the minimum objective criteria for appointment, reappointment or clinical privileges;
- f. The expiration of provisional Medical Staff membership for failure to obtain board certification within the prescribed time limits, or for failure to obtain or maintain any other mandatory requirement for Medical Staff membership;

- g. The imposition of supervision or observation on a Medical Staff member that does not restrict his or her clinical privileges or the delivery of professional services to patients;
- h. The issuance of a letter of warning, admonition, or reprimand;
- i. Corrective counseling;
- j. A recommendation that the Practitioner be directed to obtain retraining, additional training, or continuing education; or
- k. Any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Practitioner, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Practitioner.

**Article X:  
Hearing and Appellate Review Procedure**

**Section 1. Right to Hearing**

A Practitioner is entitled to a Hearing before a committee of the Medical Staff when s/he receives notice that the Executive Committee or the Board is recommending that any of the following actions be taken against him/her:

- a. The denial of Medical Staff appointment or reappointment;
- b. The suspension or revocation of Medical Staff membership; and/or
- c. The denial, reduction, suspension or revocation of clinical privileges.

**Section 2. Notice of Recommendation**

When a recommendation is made, which, according to the *Bylaws of the Medical Staff*, entitles a Practitioner to a Hearing prior to a final decision by the Board of Directors, the affected Practitioner will promptly be given notice by the President, in writing, certified mail, return receipt requested. The notice will contain:

- a. A statement of the recommendation made and the general reasons for it;
- b. Notice that the Practitioner has the right to request a Hearing on the recommendation within thirty (30) days of receipt of this notice; and
- c. A copy of this Article outlining the rights in the Hearing.

**Section 3. Request for Hearing**

The Practitioner has thirty (30) days following his/her receipt of such notice to file a written request for a Hearing with the President. The failure of the Practitioner to request a Hearing constitutes a waiver of his/her right to such a Hearing and to any appellate review to which s/he might otherwise be entitled. If such a right to a Hearing is waived, the recommendation of the Executive Committee becomes effective against the Practitioner pending the Board of Directors' decision relative thereto.

#### **Section 4. Notice of Hearing**

- a. Within fourteen (14) days after the receipt of the Practitioner's request for Hearing, the President will schedule a Hearing. The Hearing date will not be less than thirty (30) days from the date on which the notice of Hearing is forwarded to the Practitioner, unless an earlier date is agreed upon in writing by the parties.
- b. The President will forward the notice of Hearing to the Practitioner by certified mail, return receipt requested. The notice of Hearing will include:
  - (1) the date, time, and location of the Hearing;
  - (2) a proposed list of witnesses, as known at the time, who will give testimony or present evidence at the Hearing in support of the Executive Committee;
  - (3) the names of the Hearing Panel members/Hearing Officer, if known; and
  - (4) a statement of the specific reasons for the recommendation, as well as the list of patient records or other information supporting the recommendation. This statement and the list of supporting patient records, and other supporting information, may be revised or amended at any time, even during the Hearing so long as the additional material is relevant so as to give the Board of Directors as complete a record as possible.

#### **Section 5. Appointment of Hearing Panel, Presiding Officer, or Hearing Officer**

- a. When a Hearing is requested, the President, after consulting with the Chief of Staff, will appoint a Hearing Panel which will be composed of not less than three (3) members. The Hearing Panel will be composed of Medical Staff members, or other physicians or laypersons not connected with the Hospitals, or any combination of the above, none of whom will have actively participated in the consideration of the matter at any previous level. Knowledge of the matter will not preclude any individual from serving as a member of the Hearing Panel. The President will also designate one member of the Hearing Panel as Chair or appoint another person as the Presiding Officer.
- b. In lieu of a Hearing Panel Chair, the President may appoint an attorney at law as Presiding Officer. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but will not be entitled to vote on its recommendations. If a Presiding Officer is not separately appointed, the Chair of the Hearing Panel will serve as the Presiding Officer and will be entitled to one (1) vote. The Presiding Officer (or Hearing Panel Chair) may be advised by legal counsel to the Hospitals. The Presiding Officer (or Hearing Panel Chair) will:
  - (1) act to ensure that all participants in the Hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable numbers of witnesses and duration of direct and cross examination, applicable to both sides as may be necessary to avoid excessive or irrelevant testimony or to prevent undue delay or abuse of the Hearing process;

- (2) maintain decorum throughout the Hearing;
  - (3) determine the order of procedure throughout the Hearing;
  - (4) have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence; and
  - (5) act to ensure that all information relevant to the matter is considered by the Hearing Panel in formulating its recommendations.
- c. As an alternative to the Hearing Panel, the President, after consulting with the Chief of Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

#### **Section 6. Hearing Procedure**

- a. There is no right to discovery in connection with the Hearing. However, the Practitioner is entitled to obtain, upon specific request, subject to a stipulation signed by both parties that such documents will be maintained as confidential and will not be disclosed or used for any purpose outside of the Hearing:
- (1) copies of, or reasonable access to, all patient records identified in the notice of Hearing, as revised or supplemented, at the Practitioner's expense;
  - (2) reports of experts or other documents relied upon by the Chair, the Credentials Committee, any ad hoc committee, the Executive Committee, or the Board of Directors; and
  - (3) redacted copies of relevant committee or department minutes (such provision does not constitute a waiver of the State Medical Review Committee statute).
- b. The Presiding Officer will require the Practitioner (or his/her counsel) and counsel for the Executive Committee or the Board of Directors to participate in a pre-Hearing conference for the purpose of resolving all procedural questions in advance of the Hearing. The Presiding Officer may specifically require the parties to present at the pre-Hearing conference: any objections to the composition of the Hearing Panel or appointment of a Hearing Officer; the names of their respective counsel who will appear at the Hearing; all documentary evidence to be submitted at the Hearing and any objections to such documents; the names of all witnesses and a brief statement of their anticipated testimony; and the time granted to each witnesses' testimony and cross-examination. Witnesses and documents not provided and agreed upon pursuant to the pre-Hearing conference may be excluded from the Hearing, however, at the discretion of the Hearing Officer the list of witnesses or documents may be supplemented or amended during the course of the Hearing, provided that notice of the change is given to the other party.

- c. No Hearing will be conducted in the absence of the Practitioner unless the Practitioner waives such appearance in writing, or fails to appear at the Hearing after notice has been given. A Practitioner who fails to appear is deemed to have waived his/her rights as set forth in this Article and to have voluntarily accepted the recommendation or decision in question, which thereupon becomes final and effective pending the Board of Directors' decision relative thereto.
- d. A record of the Hearing will be kept. The method by which the record is kept is determined by the committee, and may include the use of a court reporter, electronic recording unit, or any other method that ensures that a fair and complete record is kept. The cost of a court reporter will be borne by the Hospitals, but copies of the transcript will be provided to the Practitioner requesting the Hearing at the Practitioner's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in this State.
- e. The Executive Committee or the Board of Directors, depending on whose recommendation prompted the Hearing initially, will first present evidence in support of its recommendation. Thereafter, the burden then shifts to the Practitioner or his/her representative to present evidence.
- f. At a Hearing both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: to be represented by an attorney or other person of his/her choice: to call and examine witnesses to the extent available; to introduce written evidence; to cross-examine witnesses on any relevant matters and rebut any evidence; and to submit a written statement at the close of the Hearing. If the Practitioner does not testify on his/her own behalf, s/he may be called as a witness by the Executive Committee's representative and examined as if under cross-examination. The Hearing Panel or Hearing Officer may question the witnesses, call additional witnesses, or request additional documentary evidence.
- g. The Hearing need not be strictly conducted in accordance with the rules of evidence. Any relevant evidence, if it is the sort of evidence upon which reasonable persons customarily rely in the conduct of serious affairs, will be considered, regardless of the admissibility of such evidence in a court of law. The guiding principle for the determination of admissibility of evidence is that the Board of Directors, which renders the final decision in a matter, will have before it all information relevant to the Practitioner's qualifications or conduct. Prior to or at any time during the Hearing, each party is entitled to submit memoranda concerning any issue of law, procedure or fact, and such memoranda will become a part of the Hearing record.
- h. Postponements and extensions of time beyond any time limit set forth in this Article may be requested by anyone but will be permitted only by the Presiding Officer or the President on a showing of good cause.

#### **Section 7. Hearing Conclusion, Deliberations, and Recommendations**

- a. The Presiding Officer may recess the Hearing and reconvene at a later date for the convenience of the participants or for purposes of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of all the evidence or upon a

decision by the Presiding Officer that the remaining evidence will be cumulative or irrelevant, the Hearing will be closed.

- b. The Hearing Panel will recommend in favor of the Executive Committee or the Board of Directors unless it finds that the Practitioner who requested the Hearing has proved that the recommendation of the Executive Committee or the Board of Directors, depending on whose recommendation prompted the Hearing initially, was arbitrary, capricious, or not supported by substantial evidence.
- c. The decision of the Hearing Panel will be based on the evidence produced at the Hearing, including oral testimony of witnesses, memorandum presented in connection with the Hearing, all applications, references, and accompanying documents, medical records, and any other evidence that has been submitted.
- d. Within fourteen (14) days after final adjournment of the Hearing (which will be designated as the time the Hearing Panel receives the Hearing transcript or any post-Hearing memoranda, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer and will render a recommendation, accompanied by a report, that will contain a concise statement of the reasons for the recommendation.
- e. The Hearing Panel will deliver its report to the President who will forward it, along with all supporting documentation, to the Board of Directors for further action. The President will also send a copy of the report and recommendation to the Practitioner by certified mail, return receipt requested, and to the Executive Committee for information.

#### **Section 8. Appellate Review**

- a. Within twenty-one (21) days after receipt of notice of the Hearing Panel's recommendation, either party may request an appellate review. The request will be in writing, to the President either in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances that justify further review. If an appellate review is not requested in this manner, both parties will be deemed to have waived appellate review.
- b. The grounds to be argued on appeal are:
  - (1) that during or prior to the Hearing there was substantial failure to comply with these *Bylaws of the Medical Staff* so as to deny due process or a fair Hearing; or
  - (2) the Hearing Panel's recommendation was arbitrary, capricious, a result of prejudice, or not supported by substantial evidence.
- c. Whenever an appeal is presented as set forth in this Article, the Chair of the Board of Directors will, within seven (7) days after receipt of such request, through the President, notify the Practitioner in writing of the date, time and location of the appellate review by certified mail, return receipt requested. The date of the proceeding will not be less than ten (10) days, nor more than thirty (30) days from the date of receipt of the notice of request for appellate review. However, when the request for appellate review is from a Practitioner who is under a suspension then in effect, the appellate review will be

scheduled as soon as arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of such request. The time for appellate review may be extended by the Chair of the Board for good cause.

- d. The Chair of the Board of Directors may appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, including but not limited to reputable persons outside the Hospitals, to consider the record upon which the recommendation before it was made, or the Board may hear the appeal as a whole.
- e. Additional evidence will be accepted only if the party seeking to admit it can demonstrate that such evidence was not developed at the time of the Hearing, that any opportunity to admit it at the Hearing was denied, and then only at the discretion of the Review Panel. Each party has the right to present a written statement in support of its position on appeal. In its sole discretion, the Board or Review Panel may allow each party or its representative to appear personally and make oral argument. The Review Panel will recommend final action to the Board.

### **Section 9. Final Decision of the Board**

- a. Within thirty (30) days after receipt of the Review Panel's recommendation, the Board of Directors will render a final decision in writing, including specific reasons, and will deliver copies to the Executive Committee and, through the President, to the Practitioner by certified mail, return receipt requested. The Board of Directors may affirm, modify or reverse the recommendation of the Review Panel, refer the matter for further review and recommendation, or make its own decision in light of the Board of Directors' ultimate legal responsibility to make appointments and grant clinical privileges.
- b. Except where the matter is referred for further action and recommendation, the final decision of the Board of Directors will be immediately effective and not subject to further Hearing or appellate review. If the matter is referred for further action and recommendation, such recommendation will be promptly made to the Board of Directors in accordance with the instructions given by the Board of Directors. This further review process and the report back to the Board of Directors will not exceed thirty (30) days except as the parties may otherwise stipulate.
- c. Notwithstanding any other provision set forth in these Medical Staff Bylaws, no Practitioner shall be entitled as a matter of right to more than one Hearing and one appellate review on any matter which has been considered by either the Executive Committee of the Medical Staff or the Board of Directors.

## **Article XI: Organization of Departments and Services**

### **Section 1. General Organization**

An up-to-date list of the Departments of the Medical Staff is set forth in the *Medical Staff Organization Manual*.

## **Section 2. Organization of Departments and Services**

- a. The Chief of Staff is responsible for the clinical operations of the Hospital. The Chief of Staff calls and presides over all regular and special meetings of the Medical Staff.
- b. Each department or service shall be organized as a division of the staff and shall have a Department Chair or Service Head who is responsible to the Chief of Staff for the ongoing, effective operation of his Department or Service, for improving patient safety, and for continually assessing and improving its activities. Each Department Chair and Service Head is appointed by the Board of Directors upon the recommendation of the Dean of the School of Medicine, except that the Chair of the Department of Dentistry is appointed upon recommendation of the Dean of the School of Dentistry.
- c. A Department Chair or Service Head may be removed from that position by the Board of Directors for unsatisfactory performance of his/her responsibilities as set forth in these *Bylaws*. The Chief of Staff or the President may recommend to the Board of Directors the removal of a Department Chair or Service Head and shall give a Department Chair or Service Head notice and the grounds upon which such recommendation is based. The Department Chair or Service Head may request a discussion with the Chair of the Joint Conference Committee to be held within five (5) days of such notice. Following such discussion, the Board of Directors renders a final decision. A Department Chair or Service Head so removed shall have no further appeal rights under these *Bylaws*. Without further action taken pursuant to these *Bylaws*, removal as Department Chair or Service Head does not affect the Medical Staff appointment or clinical privileges of the physician.
- d. The Hospital may, from time to time, contract with physicians, dentists or other allied health professionals to perform various administrative duties and responsibilities on its behalf. Individuals in such administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges. All matters relative to the membership and/or privileges of such individuals are governed by these *Bylaws*.

### **Article XII: Departments and Services**

## **Section 1. Functions of Departments and Services**

- a. Each department establishes its own written criteria relative to clinical or practice privileges consistent with the policies of the Hospital, the Board of Directors and the Medical Staff.
- b. Each department and service establishes and maintains a systematic process for monitoring and evaluating all of its major clinical activities for the purpose of improving the quality of the care provided. In all such evaluation and monitoring activities, each department and service is specifically designated and will conduct such activities as a Medical Review Committee. Each department and service meets at least monthly to review selected cases that contribute to the continuing education of every practitioner and to the process of identifying opportunities for improvement in patient care. Such reviews may include an evaluation of all deaths, selected unimproved patients, patients with infections, complications in care, errors in diagnosis and treatment, and other

matters deemed to be appropriate. In addition, departments and services review patient incidents as reported by the Risk Management Department. When problems in patient care and clinical performance are identified, the department or service takes action to correct them and evaluates the effectiveness of any such action, all of which are documented at least quarterly in the quality improvement meeting minutes of each department and service and forwarded to the Clinical Management Committee.

- c. Each patient admitted for inpatient care or outpatient surgery shall have a history taken and a comprehensive physical examination (H&P) performed by an attending physician or by a Housestaff physician or Allied Health Professional with such privileges and authenticated by the attending physician. Qualified oral surgeons who admit patients without medical problems may perform the history and physical examination on those patients. An H&P shall be completed for the electronic medical record no more than twenty-four (24) hours prior to a scheduled admission or outpatient surgery or within twenty-four (24) hours after emergency surgery (the "Required Period"). In an emergency when there is no time to record a complete H&P, a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record before surgery. If all or part of the H&P is dictated, then a brief note shall be written in the record on the progress notes or typed directly in the electronic medical record upon admission to provide pertinent information until the dictated H&P is transcribed. An H&P may be performed outside the Required Period, but within thirty (30) days prior to a scheduled admission or outpatient surgery, if an updated assessment is subsequently both performed and documented during the Required Period that identifies any changes in the patient's medical status or that no changes have occurred.

## **Section 2. Responsibilities of Department Chairs**

Each Department Chair is responsible for:

- a. All clinically related activities of the department/service;
- b. All administratively related activities of the department/service, unless otherwise provided for by the Hospital or University;
- c. Continuing surveillance of the professional performance of all individuals who have delineated clinical or practice privileges in the department/ service;
- d. Recommending to the Medical Staff the criteria for clinical or practice privileges that are relevant to the care provided in the department/service;
- e. Recommending clinical or practice privileges for each member of the department/service;
- f. Assessing and recommending off-site resources for needed patient care services not provided by the Department/Service or the Hospital;
- g. The integration of the department/service into the primary functions of the organization;
- h. The coordination and integration of interdepartmental and intradepartmental services;

- i. The development and implementation of policies and procedures that guide and support the provision of services;
- j. Recommendations for a sufficient number of qualified and competent persons to provide care/service;
- k. The determination of the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services;
- l. The continuous assessment and improvement of the quality of care and services provided;
- m. The maintenance of quality control programs, as appropriate;
- n. The orientation and continuing education of all persons in the department/service; and
- o. Recommendations for space and other resources needed by the department/service.

Each Department Chair is certified by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

### **Article XIII: Officers**

#### **Section 1. Officers**

- a. Officers of the Medical Staff must be members of the Active Staff.
- b. The officers of the Medical Staff are the Chief of Staff, such Associate Chiefs of Staff as may be deemed appropriate and appointed by the Chief of Staff, and six Members-at-Large.
- c. The Chief of Staff is also the Associate Dean for Clinical Affairs in the School of Medicine. He or she is appointed by the Hospital Board of Directors upon the recommendation of the Dean of the School of Medicine, with the approval of the Executive Committee of the Medical Staff.
- d. An official slate of nominations for the Members-at-Large is placed before the membership by the Executive Committee at a regular meeting of the Medical Staff. Nominations from the membership are also requested at this meeting. Prior to the meeting, an official ballot is submitted to each voting member of the Medical Staff. The results of the election of officers are announced at the meeting.

#### **Section 2. Term of Office**

The Chief of Staff serves for terms concurrent with his/her appointment as Associate Dean for Clinical Affairs. The Members-at-Large will serve staggered two year terms or until a successor is appointed or elected.

### **Section 3. Duties of Officers**

- a. **Chief of Staff.** The Chief of Staff serves as the Chief Administrative Officer of the Medical Staff. His/Her responsibilities are as follows:
- (1) To work with the President relative to all matters of mutual concern between the Medical Staff and the Hospital;
  - (2) To call and preside at all meetings of the Medical Staff and keep complete and accurate minutes of all meetings;
  - (3) To appoint the membership of all standing, special and multidisciplinary Medical Staff Committees, except the Executive Committee, subject to the approval of the Executive Committee. Unless otherwise set forth in these *Bylaws*, the Chief of Staff names all committee Chairs;
  - (4) To serve as an ex-officio member of all Medical Staff Committees;
  - (5) To represent the views, policies, needs and grievances of the Medical Staff to the Board of Directors and the President;
  - (6) To serve as the public spokesperson for the Medical Staff;
  - (7) To report at the biannual Medical Staff meeting regarding Medical Staff affairs;
  - (8) To enforce the *Bylaws of the Medical Staff*, the *Rules and Regulations of the Medical Staff* and related Policies and Manuals and implement and monitor sanctions or corrective action taken pursuant to these *Bylaws*; and
  - (9) To serve as the Chair of the Executive Committee.
- b. **Associate Chiefs of Staff.** An Associate Chief of Staff, in the absence of the Chief of Staff, assumes all of the authority and duties of the Chief of Staff. The Associate Chiefs of Staff, also perform such other duties as may be assigned by the Chief of Staff.
- c. **Members-at-Large.** The Members-at-Large are responsible for reflecting the views of the membership in Medical Staff affairs.

### **Section 4. Removal of Officers**

- a. An officer of the Medical Staff may be removed from office for causes unrelated to professional capabilities or the exercise of clinical privileges. Such causes may include failing to perform the duties of the position, exhibiting conduct detrimental to the interests of the Hospital, or suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of the office. The Chief of Staff (or the Dean of the School of Medicine if the Chief of Staff is the subject of removal) will give an officer notice and the grounds upon which such removal is proposed. The officer may request a meeting with the Chief of Staff (or with the Dean of the School of Medicine if the Chief of Staff is the subject of removal) to be held within five (5) days of the date of such request.

Following such meeting, the Chief of Staff (or the Dean of the School of Medicine, if the Chief of Staff is the subject of removal) consults with the Executive Committee of the Medical Staff before rendering a final decision. An officer so removed has no further appeal rights under these *Bylaws*.

- b. Without further action pursuant to these *Bylaws* , removal from office does not affect the Medical Staff appointment or clinical privileges of the physician.

## **Article XIV: Committees**

### **Section 1. General**

Committees are either standing or special. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these *Bylaws* or the *Medical Staff Organization Manual*. The presence of twenty-five (25) percent of a committee's members will constitute a quorum. The members of all standing committees, other than the Executive Committee, are appointed by the Chief of Staff subject to approval by the Executive Committee, unless otherwise stated in these *Bylaws* or the *Medical Staff Organization Manual*. Unless otherwise set forth in these *Bylaws* or the *Medical Staff Organization Manual*, the Chair of each committee is appointed by the Chief of Staff. Each standing committee meets at least quarterly unless otherwise set forth in these *Bylaws* or the *Medical Staff Organization Manual*. Minutes of each meeting are recorded and forwarded to the Executive Committee. Robert's Rules of Order will govern all committee meetings.

### **Section 2. Executive Committee**

- a. The Executive Committee consists of the Officers of the Medical Staff, the Department Chairs, the Chief Nursing Officer, the President of UNC Physicians and Associates, the Deans of the Schools of Medicine and Dentistry or their designees, the President of the Housestaff Council, and the President and Chief Operating Officer of UNC Hospitals. All members are entitled to vote. The Chief of Staff is a member and Chair of the Committee.
- b. The Medical Staff delegates to the Medical Executive Committee authority to oversee the operations of the Medical Staff. With the assistance of the Chief of Staff, and without limiting this delegation of authority, the Medical Executive Committee is responsible for making recommendations to the Board of Directors for its approval concerning:
  1. The structure of the Medical Staff;
  2. The mechanisms used to review credentials and to delineate individual clinical or practice privileges;
  3. Recommendations of individuals for Medical Staff membership;
  4. Recommendations for delineated clinical or practice privileges for eligible individuals;
  5. Participation of the Medical Staff in performance improvement activities;

6. The mechanisms for terminating Medical Staff membership; and
7. The mechanisms for Fair Hearing procedures.

The Executive Committee receives and acts on reports and recommendations from Medical Staff Committees, departments and assigned activity groups, and is empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities.

- c. The authority delegated pursuant to this Article XIV, Section 2 may be removed by amendment of these *Bylaws*, or by resolution of the Medical Staff, approved by a 2/3 vote of the voting members of the Medical Staff, taken at a general or special meeting noticed to include the specific purpose of removing specifically-described authority of the Medical Executive Committee.
- d. A member of the Medical Executive Committee may be removed from the Medical Executive Committee for the reasons described in and pursuant to the process outlined in Article XIII, Section 4 (herein), provided however, that the member of the Medical Executive Committee who is the subject of removal not participate in any discussions between the Chief of Staff (or with the Dean of the School of Medicine if the Chief of Staff is the subject of removal) and the Medical Executive Committee. An member of the Medical Executive Committee so removed has no further appeal rights under these *Bylaws*.

### **Section 3. Creation of Committees**

The Executive Committee may, by resolution and upon approval of the Board of Directors, without amendment of these *Bylaws*, establish additional standing or special committees to perform one or more Medical Staff functions. In the same manner, the Executive Committee may, by resolution and upon approval of the Board of Directors, dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

## **Article XV: Meetings**

### **Section 1. Regular Meetings**

Two regular meetings of the Medical Staff shall be held each year. The Active Staff are encouraged to attend at least one of these meetings. A record of attendance shall be kept by the Chief of Staff or his or her designee.

### **Section 2. Special Meetings**

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Board of Directors, the Executive Committee, or any five (5) members of the full-time Active Medical Staff. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least forty-eight (48) hours prior thereto.

### **Section 3. Quorum**

For purposes of Medical Staff business, twenty-five (25) percent of the total membership of the Active Staff entitled to vote constitutes a quorum. The Chief of Staff, in his/her discretion, may declare a quorum at any regular or special meeting of the Medical Staff.

## **Article XVI: Rules and Organization Manual**

### **Section 1. General Rules and Organization Manual**

The Medical Staff may initiate and adopt such Rules and an Organization Manual as it may deem necessary and periodically review and revise its Rules and Organizational Manual to comply with current Medical Staff practice and to implement more specifically the general principles found in these Bylaws. Proposed Rules or Manual amendments may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least 100 members of the Active Staff. Additionally, Hospital administration may develop and recommend proposed Rules or Manual amendments, and in any case should be consulted as to the impact of any such proposed changes or amendments on Hospital operations and feasibility. Proposed Rules or Manual amendments are submitted to the Medical Staff Executive Committee for review and action, as follows:

### **Section 2. Process for Adoption or Amendment**

- a. Except as provided at Section 2d. below, with respect to circumstances requiring urgent action, the Medical Staff Executive Committee will not act on the proposed Rule or Manual amendment until the Medical Staff has had a reasonable opportunity to review and comment on such amendment. This review and comment opportunity may be accomplished by posting proposed Rules on the Medical Staff website or by sending the proposed Rules via electronic mail to the members of the Medical Staff at least 15 days prior to the scheduled Medical Staff Executive Committee meeting, together with instructions on how interested members may communicate comments during this review and comment period. All comments will be summarized and provided to the Medical Staff Executive Committee prior to Medical Staff Executive Committee action on the proposed Rule or Manual amendment.
- b. Medical Staff Executive Committee approval is required for amendments to the Rules or Organizational Manual, unless the proposed Rule or Manual amendment is one generated by petition of at least 100 members of the Active Staff. In this latter circumstance, if the Medical Staff Executive Committee fails to approve the proposed Rule or Manual amendment, it will notify the Medical Staff. The Medical Staff Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Article XVIII.
  - (1) If conflict management is not invoked within 25 days it will be deemed waived. In this circumstance, the Medical Staff's proposed Rule or Manual amendment will be forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Medical Staff and the Governing Body regarding the reasons it declined to approve the proposed Rule.

- (2) If conflict management is invoked, the proposed Rule will not be voted upon or forwarded to the Board of Directors until the conflict management process has been completed, and the results of the conflict management process are communicated to the Medical Staff and the Board of Directors.
  - (3) With respect to proposed Rules or Manual amendments generated by petition of the Medical Staff, approval requires the affirmative vote of a majority of the votes of at least 25% of the Active Staff members, provided at least 14 days' advance written notice, accompanied by the proposed Rule or Manual amendment, has been given.
- c. Following approval by the Medical Staff Executive Committee as described above, a proposed Rule or Manual amendment is forwarded to the Board of Directors for approval, which approval shall not be withheld unreasonably. The Rule or Manual amendment becomes effective immediately following approval of the Board of Directors.
  - d. Where urgent action is required to comply with law or regulation, the Medical Staff Executive Committee is authorized to provisionally adopt a Rule or Manual amendment and forward it to the Board of Directors for approval and immediate implementation, subject to the following: if the Medical Staff did not receive prior notice of the proposed Rule, the Medical Staff will be notified of the provisionally-adopted and approved Rule or Manual amendment, and may, by petition signed by at least 100 members of the Active Staff, require the Rule or Manual amendment to be submitted for possible recall; provided, however, the approved Rule or Manual amendment will remain effective until such time as a superseding Rule or Manual amendment meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 3.

#### **Article XVII: Amendment**

These *Bylaws*, are reviewed no less than once every three years by the Bylaws Committee. At any time, the Executive Committee of the Medical Staff may make recommendations for amendment of these *Bylaws*. Additionally, the Medical Staff may make recommendations for amendment of these *Bylaws* by submitting to the Executive Committee of the Medical Staff a petition signed by at least 10% of the Active Staff members entitled to vote. Hospital administration also may recommend amendments to these *Bylaws*.

To be adopted, amendments require approval by a majority of the Medical Staff members voting on the matter, provided that at least twenty-five (25) percent of the Active Staff entitled to vote cast votes. Active Staff members entitled to vote may vote at any regular or special meeting of the Medical Staff or by delivering a completed ballot to the Office of the Chief of Staff, provided at least 14 days' advance written notice, accompanied by the proposed amendments, has been given to the Active Staff members. The ballot may be submitted electronically, through U.S. mail, or by hand. Any member of the Medical Staff entitled to vote who does not submit a vote within the 14-day period shall have his or her vote counted in favor of the amendment.

Amendments that have been passed by a majority vote of the Medical Staff, as described above, become effective when approved by the Board of Directors. If approval is withheld, the

reasons for doing so will be specified by the Board of Directors in writing and forwarded to the Chief of Staff, the Executive Committee of the Medical Staff and the Bylaws Committee.

**Article XVIII:**  
**Conflict Management**

In the event of conflict between the Medical Staff Executive Committee and the Medical Staff (as represented by written petition signed by at least 100 of the voting members of the Medical Staff) regarding a proposed or adopted Rule or Organizational Manual provision, or other issue of significance to the Medical Staff, the Chief of Staff will convene a meeting with the petitioners' representative(s). The foregoing petition will include a designation of up to five members of the voting Active Staff to serve as the petitioners' representative(s). The Medical Staff Executive Committee will be represented by an equal number of Medical Staff Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) will exchange information relevant to the conflict and work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Staff Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Staff Executive Committee's representatives at the meeting and a majority vote of the petitioners' representatives. Unresolved differences will be submitted to the Board of Directors for its consideration in making its final decision with respect to the proposed Rule or Organizational Manual issue.